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	125043	A. BUILDING: _____ B. WING _____	05/07/2021

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PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

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4 000	Initial Comments A relicensing survey was conducted by the Office of Healthcare Assurance (OHCA) on May 07, 2021. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing facilities. Survey dates: May 04/21 to May 07, 2021. Survey Census: 79. Sample size: 19.	4 000		
4 112	11-94.1-27(1) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (1) The free exercise of rights as a resident of the facility and as a citizen or resident of the United States; This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to accommodate one resident's choices to have family visits in the facility, and for an appropriate length of time. The Resident (R)5 was in hospice care which necessitated having visits with family members in the facility. The facility required the resident's family members to have a COVID 19 negative test in order to visit the resident. The family visits	4 112	4112 11-94.1-27(1) Resident Rights & Facility Practices Re: Visitation Part 1: 1. Director of Nursing and Administrator reviewed R5 compassion visits with family member. It was noted that all requested in person visits as well as email communication between Director of	6/21/21

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4 112	Continued From page 1 were limited to 15 minutes. In addition, the resident did not have a radio at the bedside to listen to music that was noted to be of interest to the resident and included in the care plan. The deficient practice left the resident without social interaction and comfort which had the potential to increase feelings of isolation and loneliness. The required COVID-19 test for visitors, limited schedule of days and time during visit discouraged family members to visit residents in the facility. Findings include: Surveyor observed R5 on 05/05/21 at 10:59 AM laying in bed with the curtain pulled. The room was dark. Noted there was no TV or radio next to the bedside or any bedside table. The resident appeared awake with her eyes open staring at the ceiling, she said her back hurts. When asked if she wanted to watch tv she shook her head no, and stated, "but I like music." Surveyor interviewed a family member (FM) via telephone call on 05/05/21 at 11:10 AM. When asked if FM felt that R5's choices were being honored and her needs were being met, she responded that she was very frustrated about not being able to see her mom who is in Hospice as often as she would like to. FM stated that the Director of Nursing (DON) said I have to take a COVID test and then its only good for 30 days. "I've been vaccinated and my mothers also been vaccinated, why do I need to get a COVID test anyway?" Then once I got the negative test result I can't visit my mom for more than 15 minutes. She also said we can only visit Monday, Wednesday and Friday which makes it very hard with our schedules. When I do call the DON to schedule, I get her voicemail and leave her a	4 112	Nursing and family had in fact been acknowledged and completed as requested. Beginning April 1, 2021 the COVID-19 PCR test requirement had been stopped for all visitors, vendors, and contractors entering the building. A monthly letter is sent to all primary responsible parties and posted on the facility website outlining all visitation requirements. All personnel, including visitors, vendors, contractors, and staff are required to undergo temperature screening and COVID questionnaire completion for entry into the building. Activity staff ensure that R5 has daily access to music and other activities per resident preference. 2. Visitors for all residents will be given access to visits based on Resident preference and ability to participate. Hospice residents and those on quarantine will be given compassion/end of life access visits. All visitors, whether indoor or outdoor tent visits will continue to have temperature and COVID-19 questionnaire screening, wear masks provided by the facility and comply with all infection control requirements during their visits. Facility acknowledges that each resident□s situation is different and must be addressed individually. Tent visits are allowed for thirty to forty five minutes due to infection control cleaning and preparation for the next scheduled visit. 3. All screening staff will be educated to the current facility visitation guidelines to ensure communication consistency with written communication to resident families.	

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4 112	Continued From page 2 message, I don't get a call back. Its very hard to coordinate. I was waiting for confirmation to visit my mom and the DON only called me back half hour before, its so limited the day and time, its frustrating. Its barely enough time to say hello and goodbye. When the DON told he me needed to get the COVID test, she didn't tell me that it was only good for 30 days and then I needed to get another test. Surveyor interviewed the Administrator on 05/06/21 at 09:34 AM stated that the Administrator sets up the tent visits outside. They are scheduled Monday through Friday for 15, 20 or more minutes. The visits inside the facility are being scheduled by the DON. They are suppose to call the DON, and they can schedule to see those in Hospice or the residents who cant go downstairs. Family members are not required to get a COVID-19 test. We did require that a long time ago when Center's for Medicare and Medicaid services (CMS) came out with the guidelines and we first allowed visitors into the facility. When surveyor asked if the families are clear on the rules and requirements about the visitation rules the Administrator stated that the information is posted on the website and the facility also sent a letter to the family. Surveyor reviewed the "inside visitation" screening forms on 05/06/21 at 09:56 AM. Noted each form indicated a COVID test date and result on the top of each page. Surveyor reviewed the electronic medical record (EMR) for R5 on 05/06/21 at 10:30 AM. R5 has a history of depression, and is currently on medication for depression. R5 also has a history of refusing to eat and is at risk for further decline.	4 112	Written instructions at the screening stations for both the main building lobby and tent visitation area have been updated. Director of Nursing and Administrator will continue to schedule visits with families and provide consistent information both verbally and in writing to avoid any confusion as new updates and guidelines are received from CMS, CDC, and DOH. 4. Director of Nursing and Administrator will monitor visitations for any reported problems experienced by families, friends or residents with the visits. Director of Nursing and Administrator will give report to Quarterly Quality Committee on visitation data and family feedback. 4112 11-94.1-27(1) Resident Rights & Facility Practices Re: Visitation Part 2: 1. Administrator and DON discussed visitation concerns with R47. R47 was reassured that all visits with family members were not limited to 15 minutes. R47 has infrequent visits with several extended family members who have all been notified verbally and in writing about the updated facility indoor and outdoor visitation policies. R59 and R32 reside in Facility ventilator dependent unit. Family of R59 has had little to no visits with R59 since R59 admission in 2018. Family is notified in writing monthly of facility visitation however family has not contacted anyone at the facility to request a visit. R32 has numerous family	

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4 112	Continued From page 3 Care plan reviewed. Problem/ Need: R5 has a history of anxiety, depression, agitation, and restlessness. Strength: R5 has a daughter who visits her every morning and is available for phone calls. Interventions. Encourage socializing with relatives through visits and phone calls... o Use relaxation techniques such as soft music, deep breathing, visualization. Surveyor reviewed the Visitors During COVID-19 Pandemic Restrictions effective: 12/16/20, Revised: 03/22/21. Policy: ...The Director of Nursing will determine which residents are able to participate in outdoor visits. The DON will be the point of contact for compassionate indoor visits for residents unable to tolerate an outdoor tent visit... Surveyor interviewed the DON on 05/07/21 at 10:06 AM. At the beginning we required the visitors get a COVID test, I don't remember a date. For those who can't tolerate to go down. The Administrator and I divided the responsibilities. I review and assess the resident and how they can tolerate. Some residents are in quarantine. unless they are dying, I'll make exceptions. With a later instruction from CMS, and Department of health, we are no longer required to ask visitors to test. Most family calls to visit, if they call and leave a message I get back to them or the call is forwarded to the floor. When they call I tell them we don't require testing. We give them 15 minutes at a time for the visit. We allow them to have 15 minutes to minimize the exposure. If the resident is vaccinated we allow them to come and stay longer.	4 112	members who arrange visits within the Ventilator unit. They have been updated verbally and in writing monthly about visitation and have not been asked to obtain a COVID-19 test since March 2021. 2. Visitors for all residents will be given access to visits based on Resident preference and ability to participate. Hospice residents and those on quarantine will be given compassion/end of life access visits. All visitors, whether indoor or outdoor tent visits will continue to have temperature and COVID-19 questionnaire screening, wear masks provided by the facility and comply with all infection control requirements during their visits. Facility acknowledges that each resident□s situation is different and must be addressed individually. Tent visits are allowed for thirty to forty five minutes due to infection control cleaning and preparation for the next scheduled visit. 3. All screening staff will be educated to the current facility visitation guidelines to ensure communication consistency with written communication to resident families. Written instructions at the screening stations for both the main building lobby and tent visitation area have been updated. Director of Nursing and Administrator will continue to schedule visits with families and provide consistent information both verbally and in writing to avoid any confusion as new updates and guidelines are received from CMS, CDC, and DOH. 4. Director of Nursing and Administrator	

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4 112	Continued From page 4 Surveyor interviewed FM a second time on 05/07/21 at 10:26 AM. Stating that her daughter emailed the DON earlier in the week to arrange a visit with R5 today. When she came to visit R5, she was told she was not on the list and had to wait outside. Then they wanted to bring R5 outside, and my daughter told them she can't go outside since she's so frail. Eventually they let her go in to see R5. Surveyor interviewed the DON on 05/07/21 at 12:19 PM when asked if the radio's are provided by the facility, stated we have radios to give to each resident. The family can also bring a television or radio. Activity aids also have a radio they go room to room. Surveyor reviewed the Visitors During COVID-19 Pandemic Restrictions effective: 12/16/20, Revised: 03/22/21. Policy: ...The Director of Nursing will determine which residents are able to participate in outdoor visits. The DON will be the point of contact for compassionate indoor visits for residents unable to tolerate an outdoor tent visit. Surveyor reviewed CMS Ref: QSO-20-39-NH September 17, 2020 Revised 03/10/2021. Nursing Home Visitation-COVID-19 (REVISED). "Indoor Visitation. Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times)...For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of	4 112	will monitor visitations for any reported problems experienced by families, friends or residents with the visits. Director of Nursing and Administrator will give report to Quarterly Quality Committee on visitation data and family feedback.	

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4 112	Continued From page 5 COVID-19 infection prevention. Visitor Testing and Vaccination...while visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation... Compassionate Care Visits...Compassionate care visits, and visits required under federal disability rights law, should be allowed at all time, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak." (Cross reference to F563 right to receive visitors). 2)Based on observation, interview and record review the facility failed to provide three residents (R)5, 47, and 59 the right to have visitors in the facility for a period of time that was acceptable to the Residents and their families. The facility required family members to complete a COVID-19 test with a negative test result within 30 days of each visit to the facility. The deficient practice has the potential to increase feelings of loneliness and isolation for residents who reside in the facility. The testing requirement discourages family members to visit family members. Findings include: 1) Surveyor interviewed R47 on 05/04/21 at 12:47 PM. When asked if he was able to make choices about his care while residing in the facility stated that he would like to have more time to visit with his family. "Even a half hour would be okay, we only get 15 minutes, its just not enough time. The ladies in the front have a timer who tells you times up and my family have to leave. R47 stated that he did not receive any thing in writing about the visit rules. Its only 15 minutes". R47 is	4 112		

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4 112	Continued From page 6 a 56 year old alert and oriented male. He has a history of stroke and now stays at the facility. Surveyor observed the tent in the parking garage on 05/05/21 at 10:30 AM, when asked how long the visits last between the family members and residents, one of the staff stated "15 minutes". 2) Surveyor interviewed a family member (FM) of R5 via telephone call on 05/05/21 at 11:10 AM. who stated that she was very frustrated about not being able to see her mom who is in hospice care as often as she would like to and for more than 15 minutes. FM stated that the Director of Nursing (DON) said I have to take a COVID test and then its only good for 30 days. Once I got the negative test result I can't visit my mom for more than 15 minutes (cross reference F561 choices) it seems like its hardly worth all of the effort. Surveyor interviewed the Administrator on 05/06/21 at 09:34 AM stated that the Administrator sets up the tent visits outside. They are scheduled Monday through Friday for 15, 20 or more minutes. The visits inside the facility are being scheduled by the DON. They are suppose to call the DON, and they can schedule to see those in Hospice or the residents who can't go downstairs. Family members are not required to get a COVID-19 test. We did require that a long time ago when the Centers for Medicare and Medicaid services (CMS) came out with the guidelines and we first allowed visitors into the facility. When asked if the families are clear on the rules and requirements about the visitation rules, the Administrator stated that the information is posted on the website and the facility also sent a letter to the family. Surveyor reviewed the visitation schedule on	4 112		

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4 112	Continued From page 7 05/05/21 09:56 AM. Starting in December visits were scheduled Monday, Wednesday and Friday, each in a 1 hour slot. Current week (during the survey) was one visit scheduled on Monday, Tuesday, a few on Wednesday, several on Thursday and Friday. scheduled at 1 hour increments. Surveyor interviewed the DON on 05/07/21 at 10:06 AM. At the beginning we required the visitors to get a COVID test, I don't remember a date. With a later instruction from CMS, and Department of health, we are no longer required to ask visitors to test. Surveyor asked DON if there is a time limit for the family, we give them 15 minutes at a time. We allow them to have a leeway for 15 minutes due to the risk of exposure, if the resident is vaccinated we allow them to come and stay longer. During an interview with a Registered Nurse (RN) on 05/06/21 at 10:50 AM, stated they schedule the visits everyday and we get a list of the names and times of the residents on our unit. The visits last 15 minutes. Surveyor reviewed the Visitors During COVID-19 Pandemic Restrictions effective: 12/16/20, Revised: 03/22/21. Policy: ...2 visitors per resident, with a visit limit of 15 minutes... Surveyor reviewed CMS Ref: QSO-20-39-NH September 17, 2020 Revised 03/10/2021. Nursing Home Visitation-COVID-19 (REVISED). "Visitor Testing and Vaccination...while visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation...	4 112		

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4 112	Continued From page 8 3) Interview on 05/06/21 at 2:45 PM with Director of Nursing (DON) was done. DON stated that she handled the visitations in the facility and the administrator handled the visits outside in the tent. DON stated there was no COVID in the facility and that 20 residents have not received vaccination. Resident (R59)'s family (F)1 was interviewed on 05/07/21 at 11:46 AM. F1 stated that he had not seen R59 since COVID started. F1 stated that he was notified of the visits with one of his bills. R1 said he still must get a COVID test and the time to visit is limited to 15 minutes. It's not that easy. F1 went on to say that he has not been notified about not needing a COVID test. He also does not go on the web. R32's family (F)2 was interviewed on 05/07/21 at 11:31 AM. F2 stated she had a COVID test scheduled next week to visit. F2 stated, I must get a COVID once a month to visit and its only for 15 minutes once a week. The cost of the test and minimal amount of time to visit was hard. F2 further stated that she was not aware she did not need a COVID test to visit and was not notified about this change. Interview with DON on 05/07/21 at 09:20 AM. DON stated they had the current guidelines distributed by Centers for Medicare and Medicaid Services	4 112		
4 141	11-94.1-36(e) Admission, transfer, and discharge (e) At the time of transfer for hospitalization or therapeutic leave, the facility shall provide written information to the resident concerning the	4 141		6/21/21

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4 141	Continued From page 9 facility's bedhold policy. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to send a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Findings: Record Review (RR) of resident (R)59 on 05/05/21 at 09:31 AM was done. RR revealed R59 had gone to the emergency room a few times for pneumonia and bloody stools, R59 was hospitalized 3/19/21 at an acute care hospital. Surveyor was not able to find a notice to the ombudsman. Interview on 05/07/21 at 11:27 with social worker (SW) was done. SW stated that it would be done by the nurses on weekends and that they have a binder on the floor. Interview on 05/07/21 at 12:00 PM was done with Unit Supervisor (Supvr) 2. Supvr 2 went through the binder with surveyor. The binder did not hold any document of notice to the State Long-Term Care Ombudsman. Supvr 2 agreed that it was missed and was not aware of the binder and/or process. Supvr 2 stated "it could have been missed on the weekend."	4 141	4141 11-94.1-36(e) Admission, transfer, and discharge 1. Facility Social Worker immediately submitted a late Transfer/Discharge Notice to the Ombudsman□s Office of (R)59s 03/19/2021 hospitalization. Notice and faxed confirmation copy placed in Social Work Office Log Book. 2. Four in-services were held with licensed nursing staff on 5/18/2021 and 05/25/2021 to review the facility policy and procedure, dated 11/08/2018, pertaining to the Transfer/Discharge Notice. Education included the requirements of notifying the Ombudsman□s Office when a resident is transferred from the facility for hospitalization or therapeutic leave and the responsibility of licensed staff to complete the notification process during non-social work on-site work hours. The assigned social worker faxes the Notice to the Ombudsman on all scheduled transfers (lateral) or discharges. Copies are kept in the social work office. Nursing will complete the Transfer/Discharge Notice to the Ombudsman for all transfers for 911 or AMR calls. The Nursing department will fax the completed form to the Ombudsman. The form and the fax confirmation will be filed in a binder, kept at the nursing station. Each nursing station has its□ own binder for the residents on each respective unit. Social Worker will be notified of transfers	

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4 141	Continued From page 10	4 141	by nursing, during weekday morning Interdisciplinary Team Meetings (IDT). The social worker will log all transfers made by nursing on the facility Transfer/Discharge Tracking Form. Social worker will also check the binder to make sure that the Transfer/Discharge Tracking Form and fax confirmation sheet have been filed. 3. Four in-services were held on 5/18/2021 and 05/25/2021, to educate staff that this practice of notifying the Ombudsman was established on 11/08/2018 and is required. Nursing Supervisors will include orientation on the Ombudsman Transfer/Discharge Notice during new hire nursing orientation on the units. Nursing supervisors will remind licensed nursing staff as needed at monthly nursing staff meetings. Social workers will track unplanned, non-scheduled transfers/discharges from the nursing units. Scheduled and planned discharge Notices to the Ombudsman will continue to be completed and logged by the social workers. 4. Social workers will be notified during weekday IDT meetings of unplanned transfer/discharges from the nursing units. Social workers will log the transfers on the Transfer/Discharge Tracking Form. Social workers will send out the Notice to the Ombudsman for any missed transfers/discharges as soon as they are notified. Social work will monitor logs and report compliance to the Qtrly QA Committee Monitoring results will be reported at the Quarterly Quality Meeting.	

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4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide Resident (R)234 more interventions to ensure a safe environment to prevent her from falling. This deficient practice caused R234 to sustain a right hip fracture and needing care in an acute facility. This can potentially affect residents who are at a high risk for falls placed into quarantine. Findings include:	4 149	4149 11-94.1-39(b) Nursing Services (1) **IDR Submitted, pending. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident □ 234 who had a fall and injury last 11/30/2020 was discharged from Pearl	6/21/21

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	125043	A. BUILDING: _____ B. WING _____	05/07/2021

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4 149	Continued From page 12 1)A record review was done on 05/05/21 at 2:25 PM of R234's completed facility reported incident (FRI). R234 sustained a fall on 11/30/20 at 1:35 PM and was admitted to a local hospital on 12/02/20 for a right hip fracture. R234 was an 87-year-old female admitted to the facility on 11/17/20 for rehabilitation services. Her diagnoses included stroke with right sided weakness, dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities) and she sustained a fall at home prior to her admission to the facility. At the facility, R234 was in contact isolation and under quarantine for 14 days to rule out COVID-19. The FRI further stated " ...She is unable to express needs and wants with poor safety awareness ..." Review of R234's EMR revealed that her medical diagnosis for her admission into the facility was "aphasia following unspecified cerebrovascular disease" (difficulty communicating after a stroke). A physician encounter note for 11/17/20 described R234 as "...Unsteady, muscle weakness, high risk for falls Poor memory and safety awareness..." Health status progress notes in R234's EMR revealed that she was alert and oriented to self only and needed one-to-two-person assistance with her activities of daily living (ADL; tasks performed routinely i.e., eating, dressing, eating), moving from bed to wheelchair and vice versa and walking. Health status progress note of 11/20/20 stated, "...resident is confused and tends to get out of bed & always moving around on her bed..." A Social Services note documented on 11/20/20 stated that with the help of an Ilocano interpreter "...she usually gets up at least 5 times throughout the night, to use the restroom when she was at home. When at home resident was ambulatory	4 149	City Nursing Home and no longer in the facility. Corrective Actions implemented for the future: 1. Reviewed Policy and Procedure of Fall Prevention with all staff, with sign in sheets on 6/7/2021. DON will continue to review with nursing staff, prn. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident □ 234 who had a fall and injury last 11/30/2020 and was discharged from Pearl City Nursing Home and no longer in the facility. Corrective Actions implemented for the future: 1. Reviewed Policy and Procedure of Fall Prevention with all staff, with sign in sheets on 6/7/2021 and on going. DON will continue to review with nursing staff prn. 2. Re-enforced the implementation of 4 Ps for Admission Alert for falls which are the following: 1. Pain □- check resident every shift and prn and medicate prn. 2. Potty □- toilet resident every 2 hours and prn. 3. Personal items -□ check personal items to be within reach of resident. 4. Positioning □- reposition every 2 hours and prn.	

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4 149	Continued From page 13 with a walker, and independent with her ADLs..." A Health Status note documented on 11/21/20 revealed that R234 was "...forgetful & confused at times. Keep moving in bed, tossing & turning, high risk for fall..." An Incident Note on 11/23/20 documented that R234 fell from her wheelchair when she was left unattended in her room after therapy, despite having an accessible call light and a personal alarm. A review of R234's "At Risk for Falls" care plan revealed that interventions dated for her admission of 11/17/20 revealed no plan for increased rounding by staff despite R234 experiencing a fall at home prior to admission. There was also no plan for increased staff monitoring after her first fall in the facility on 11/23/20. An intervention to not leave the resident unattended in her room was also not documented. This was an intervention identified to be included in R234's care plan after her 11/23/20 fall as stated in the "Resident Incident Report" of 11/23/20. In an interview with the DON on 05/06/21 at 3:10 PM, she was queried as to why R234 was not placed closer to the nursing station after her first fall and she stated that there was no vacant room, so they did not relocate the resident. An interview with the speech language pathologist (SLP) on 05/07/21 at 11:17 AM was done. The SLP was asked about the second fall R234 had on 11/30/20. She stated that she saw R234 by the door to the room. R234 told her that she was "getting up to go and wash the dishes." SLP stated, "I must have heard the alarm" and that's why she went towards the room. She further stated that R234 was alone in the room and "was nowhere near the bed."	4 149	3. Falling Star □ implemented at room door to visually signify to staff that resident is at risk for fall. 4. Round on newly admitted resident every hour for [24] x5 days until stable and a baseline assessment is completed including cognitive status. Completed staff review on 6/7/2021 and ongoing. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? a) Due to COVID-19 admission protocols, newly admitted residents are placed in isolation rooms. COVID Vaccinated resident for 5 days, Unvaccinated resident for 14 days. b) Upon admission, Licensed staff will complete initial fall assessment to determine if resident is at risk for fall, poor safety awareness, or had a history of fall. From initial assessment, Licensed Nurse will determine the need for a low bed, bed side mat and bed/personal/wheelchair alarm if indicated. c) Nursing staff will observe residents behavioral adjustment and determine if resident needs to be located closer to the nursing station. If observation includes persistent restlessness and/or agitation, facility will implement 1:1 assistance for safety. d) Family member(s)and/or ROP will be notified to visit resident for compassion visits to make resident feel secure and improve orientation. e)Quarterly, significant change and annual fall assessments will be done thereafter and on going.	

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4 149	Continued From page 14 In another interview with the DON on 05/07/21 at 2:24 PM, she stated that R234 was not relocated to a different room because she was under quarantine for COVID-19. She did her rounds on the units and did not receive a report of R234 getting out of bed and that R234 remained calm and stayed in bed. She also stated that she did not update R234's care plan with the intervention of not leaving the resident unattended in her room. Surveyor asked the DON for documentation indicating that frequent rounding was done by staff, but none was received. 2)Based on observation and interview, the facility failed to identify poor oral health for one Resident (R)65 had foul mouth odor. The deficient practice placed the resident at a high risk for illness. Findings include: R65 is a 78 year old man who has a diagnosis of dysphagia (difficulty swallowing) requiring Gastrostomy tube (G-tube) feeding (parenteral nutrition). The resident is totally dependant on staff for his routine care and activities of daily living. During an observation on 05/04/21 at 02:35 PM. Surveyor attempted to engage R65 in conversation. Resident appeared to be non English speaking but opened his mouth to say some words. Surveyor noted a strong foul mouth odor. The resident in the bed next to the door stated that the resident (R65) is only Chinese speaking. His teeth appeared intact. During another observation on 05/06/21 at 02:50 PM, surveyor did not see a toothbrush or	4 149	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a) Upon admission, initial assessment for fall risk will be completed. b) Implement Monitoring Log for Fall to track identified resident at risk for fall. c) Quality Assessment and Prevention Intervention which consist of Interdisciplinary Team will meet after each fall incident to discuss the Root Cause Analysis of the fall. d) IDT will revise care plan and implement interventions to prevent further fall. e) RN Supervisor will monitoring Tracking Log for falls every week x 3 months and monthly for a year. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur again. What program will be into place to monitor the continued effectiveness of the systemic changes. a) Director of Nursing and/or designee will review fall outcomes on Monitoring Log and make adjustments according to results. b) Director of Nursing and/or designee will implement new adjustments and continue to review monthly. c) Director of Nursing and/or designee will monitor the tracking tool for fall incidents every month x 6 months, then quarterly. DON will submit report to the Quality Improvement meeting every quarter.	

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4 149	Continued From page 15 toothette on the bedside cabinet. Resident was sitting upright in bed awake and alert. Surveyor reviewed the Policy and procedures "Oral Assessment dated 08/24/11; and procedure for Oral Hygiene dated 11/95; 5. Care for the unconscious or edentulous resident with no dentures. b. Clean mouth using toothette's moistened with water and mouthwash. Rub toothette on chewing, inner, and out surfaces of teeth. Swab roof of mouth, inside of cheeks and along gum lines, and lips. Swab tongue. Apply petroleum jelly to lips." Surveyor observed R65 in bed on 05/07/21 at 10:55 AM , with certified nurse aide (CNA) 15 at bedside with shower gurney. CNA15 stated R65 just came back from shower. When asked how often his oral care is done and how does she clean his mouth stated, we use the toothette's. Interview with Registered Nurse (RN)25 on 05/07/21 at 11:07 AM at the nurses station. Surveyor asked if RN25 is aware of the strong mouth odor that R65 has? RN1 stated yes that he was aware, and that he ask's the CNA's to provide oral care for R65 a couple of times a shift so I don't know why its like that. Sometimes R65 refuses when they tray and he shakes his head no. He is Chinese speaking so we try to communicate with him by using gestures. When asked how often he gets an oral exam stated, I'm not sure, I think a reminder will come up in the computer, to remind us when its due. Surveyor reviewed residents hard chart on 05/07/21 at 11:28 AM. Initial/ Annual oral assessment dated 04/10/20. Missing teeth, #18 #19 #28. Root exposure and blackened areas. Gingiva is pink.	4 149	(2)Resident with Poor Oral Care/Hygiene 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident - R65 oral hygiene/care included with her ADL care was done immediately on 5/7/2021 and on going. Director of Nursing will review and re implement the Policy and Procedure on Oral care/hygiene included with ADL care to all nursing staff on 6/7/2021 and on going. Staff will be reeducated that Oral assessment by the Dentist is done annually and residents will be referred on a prn basis if an oral problem occurs. Nursing staff will be educated to perform and demonstrate oral hygiene correctly with sign in sheet on 6/7/2021 and on going. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Upon admission, resident initial oral care assessments are completed. This follows on quarterly, annually and prn. Oral Care assessments are included in residents electronic record system. Referral will be made to the Dentist whenever there is a problem encountered in oral cavity such as pain, toothache or foul odor. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	

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4 149	Continued From page 16 Surveyor reviewed the Dental Consult for R65 dated 11/09/20. "patient presents for consult regarding fractured teeth, whether he can proceed to eat. Oral hygiene is fair... Surveyor interviewed the Director of Nursing (DON) on 05/07/21 at 12:34 PM and discussed R65's oral status. The DON stated that the nurses don't need to wait for the annual dental oral assessment, if there is a concern they can refer R65 for a dental consult. 3)Based on observations, interviews and record review, the facility failed to appropriately treat Resident (R)233's pain consistent with professional standards of practice as outlined in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual - Appendix PP, Guidance to Surveyors for Long Term Care Facilities. This deficient practice can potentially impair R233's function, mobility and mood thereby diminishing her quality of life and can affect all residents experiencing pain. Findings include: An initial observation of R233 was done on 05/04/21 at 10:28 AM. R233 was calling out for help. A sign for "Contact Isolation" was posted above the room number. She was grimacing and her eyes were clenched closed while the surveyor asked if she was okay. R233 did not answer the surveyor and continued to ask for help. A record review of R233's electronic medical record (EMR) was done later that same day at 1:18 PM. R233 was admitted on 04/27/21 from a local hospital for hospice services. She had a diagnosis for gangrene (dead tissue) of her right foot. Physician's orders revealed that R233 had	4 149	Director of Nursing will develop a Monitoring Log sheet for residents oral care/hygiene compliance every shift. RN Supervisor will monitor oral assessment completion and submit to the Director of Nursing every week for 3 months, then yearly thereafter. Provide adequate oral hygiene supplies for Certified Nurses Assistance/ Licensed Nurses to use and monitor supply availability daily x 1 month, weekly x 3 months then monthly x1 year. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur again. What program will be into place to monitor the continued effectiveness of the systemic changes. Director of Nursing or designee will monitor Oral Hygiene Tracking Log completion and compliance and present to Quarterly Quality Committee. (3)Pain Management 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Director of Nursing will review Policy and procedure for Pain Management with all Licensed Nursing Staff on 6/7/2021. Licensed Nursing Staff will watch the Pain management Video on 6/8/2021 and on going. Pain assessment every shift will be included as the 5th Vital sign in residents electronic record system.	

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4 149	Continued From page 17 Tylenol Tablet (over the counter pain medication) and Oxycodone Hcl (hydrochloride; opioid pain medication) ordered to be given when she complained of pain. Social Services and Health status progress notes showed that she was alert and oriented to self, place, and time. She had gangrene of both her right and left feet and wore foam boots. R233's care plan did not describe any non-medical interventions for management of her pain. An observation and attempt at an interview were made with R233 on 05/05/21 at 10:52 AM. A television was next to her bed, but it was not on. R233 stated that she liked to watch television, but the cable was not working in her room. Surveyor confirmed with R233 that watching television would distract her from her pain. The interview was terminated because she was not conversive and stated, "okay" to all questions asked. A record review on 05/05/21 at 2:40 PM of the facility's "Pain Management" policy effective 02/19/07 revealed " ...6. Non-pharmacological intervention should be offered and taught: a. Cold packs as prescribed b. Repositioning, turning and/or ambulating as tolerated. c. Relaxing exercises i.e.: deep breathing, rhythmic breathing and/or "peaceful past" memory meditation. d. Distraction ..." Another observation and an attempt at an interview were made with R233 on 05/06/21 at 08:25 AM. R233 was lying in bed with her breakfast tray in front of her, 40% was eaten. She was grimacing and her eyes were clenched closed. Surveyor asked her if she was experiencing pain and she stated, "yes." R233	4 149	2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Upon admission, Nursing Staff will complete initial Pain Assessment on all residents in electronic system and determine if resident is in pain. This will include quarterly, annual and any significant change in condition assessments. Licensed Staff will follow non-pharmacological intervention as well as pharmacological intervention if ineffective. Licensed Staff will also follow the Pain Scale System 0-10 accordingly for pain evaluation. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Director of Nursing will develop Monitoring Log to track the completion and accuracy of Pain Assessment in residents electronic system. RN Supervisor will monitor the completion of Pain Management Log every week for 3 months then monthly X 1 year. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur again. What program will be into place to monitor the continued effectiveness of the systemic changes. Director of Nursing and/or designee will monitor Pain assessment log every month. Reports will be submitted to the Quarterly Quality Improvement Meeting. (4)	

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4 149	Continued From page 18 stated that she needed her more pain control and rated her pain eight out of ten (on a pain scale with zero being no pain to ten being excruciating pain). Surveyor informed registered nurse (RN)3 that R233 was complaining of eight out of ten pain at 08:36 AM. RN3 stated "Okay" and continued to prepare her medications for her residents. Periodic observations of RN3 revealed that she continued to prepare and administer medications to residents until 09:34 AM when surveyor queried RN3. RN3 was asked if R233 received any pain medication this morning when surveyor informed her of R233's pain and she stated "no." RN3 further stated that she had recently asked R233 if she had pain and resident stated "no." Surveyor observed R233 lying in bed snoring. On 05/06/21 at 09:26 AM, an interview with RN4 was conducted at the unit's nursing station. RN4 was queried as to what the nursing process was for when a resident complains of pain and she stated that her process is to immediately assess the resident, try to reposition the resident if needed or provide distraction activities and administer pain medication as appropriate. She stated that if she were in the middle of medication preparation for other residents, she would make sure she labeled the medication cup, put it in a safe place, lock her cart and assess the resident. On 05/07/21 at 10:15 AM, an interview was conducted with the Activities Aide (AA) in the recreation room, and she stated that R233 did not have cable for her television because the "family" needed to set up cable service. The AA stated that she did activities with R233 in the afternoon and noted that resident did have a "lot of pain."	4 149	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Director of Nursing will develop a Notification Memo to all dialysis facilities instructing them to inform our facility by phone whenever they send our resident to the hospital or Emergency Room. The Memo will be attached to the resident's communication book (pre- and post dialysis folder). Corporate contracting officer is currently working with dialysis providers to update existing contracts. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Upon admission, Nursing Staff will determine if resident is on dialysis. A dialysis communication folder will be implemented which consists of the scheduled days and times of the dialysis schedule. This form will be filled out by Nursing Staff pre-dialysis and the dialysis staff will complete post dialysis observation. Notification Memo will be attached to the Communication Folder each time resident will go to dialysis appointment. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing Staff will be educated on the Notification Memo that goes with the dialysis communication folder that goes with the resident to dialysis each time. Director of Nursing will in-service nursing staff on the implementation of the	

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4 149	Continued From page 19 On 05/07/21 at 10:30 AM a review of R233's medication administration record (MAR) was done. Oxycodone Hcl 5 mg (milligrams), 0.5 tablet (or 2.5 mg) was given once on 05/02/21. Oxycodone 5 mg, one tablet was given once on 05/03/21. Tylenol tablet 325 mg, two tablets were given once each day on 05/04/21 and 05/05/21. The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 11-22-17) stated, "Because pain can significantly affect a person's well-being, it is important that the facility recognize and address pain promptly." Strategies for pain management include " ...Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management ..." 4)Based on observation, interview and record review, the facility failed to ensure dialysis services were consistent with professional standards of practice. This deficient practice has the potential to affect other dialysis residents in the facility who require dialysis. Findings include: Interview was done on 05/06/21 at 11:39 AM with Unit Supervisor (Supvr)2. Supvr2 stated that resident (R)79 was admitted to the hospital from after leaving the facility from the dialysis center. Supvr2 stated that the transporter called the facility inquiring where the resident was for pick up. Approximately at 4:30 PM, the facility called the dialysis center to inquire where R79 was. The dialysis center stated that at 2:00 PM, they sent the resident to the emergency room. The dialysis center stated they were about to call the facility to inform them that R79 was sent out to the emergency room because of mental status changes.	4 149	Notification memo for all residents going to dialysis and on going. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur again. What program will be into place to monitor the continued effectiveness of the systemic changes. RN Supervisor will submit monitoring log every week for 2 months and monthly for a year to the Director of Nursing. Director of Nursing and/or designee will monitor the completion of dialysis communication folder every week for residents on dialysis. Reports will be presented to Quarterly Quality Improvement Meeting	

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4 149	Continued From page 20 Supvr 2 stated she followed up with the hospital and R79 was admitted. Supvr2 stated that the dialysis center is supposed to communicate with the facility via the dialysis communication record (DCR), however, no DCR or phone call had been received. Supvr 2 stated that she is still waiting for a DCR from the dialysis center. DCR was not received until 05/06/21 at 2:30 PM. R49 was admitted to an acute facility on 05/05/21 at approximately 2:00 PM according to Registered nurse (RN)2. Treatment was scheduled for 11:45 PM to 3:15 PM on 05/05/21 with the dialysis center. Record review on 05/07/21 at 09:52 AM of the facilities contract revealed a contract dated from 2011 and 2012 with a previous administrator's name. Record review on 05/07/21 at 10:00 AM of facilities policy and procedure dated April 29, 2011 states under Procedure: 4. The facility will communicate with dialysis agent any significant medical/health changes the resident may encounter. The dialysis agent is also expected to provide similar notifications affecting the resident while on dialysis. 5. The facility will manage the resident's care and well being in collaboration with the recommendations and treatment modalities set forth by the dialysis agent. 6. The facility will be responsible in arranging transportation (e.g. family transport other private arrangements) and escort as appropriate, to ensure safe arrival to and departure from the dialysis site. Interview on 05/07/21 at 10:30 with the Director of	4 149		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 21 Nursing (DON) and Administrator. DON stated that the contract was old. The facility did not update the contract because the residents who were admitted to the facility from dialysis are already in place before they even come here. The DON and administrator understood the event of miscommunication for R79 was not professional standards of practice. This deficient practice has the potential to affect other dialysis residents in the facility.	4 149		
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation, staff interview, record review, and review of equipment service manual, the facility failed to ensure routine maintenance of the air particle filter, based on the manufacturer's recommendation, for one two of four oxygen concentrators reviewed. This deficient practice put Resident (R) 42 and Resident (R) 63 at risk for the development and transmission of communicable diseases and infections. Findings Include: 1. During an observation, on 05/05/21 at 11:00 AM, of R42's room, a NewLife Elite Oxygen Concentrator was noted at bedside providing oxygen to R42. The air particle filter located on the back of that oxygen concentrator appeared dirty with lint and/or dust on it. A review of the Electronic Health Record (EHR) showed that R42 was admitted on 03/20/20 with a	4 243	4243 11-94.1-16(a) Engineering and Maintenance 1. All in-use oxygen concentrators and filters in facility were immediately cleaned and checked per the manufacturers standards to ensure safety and infection control for the effected residents. 2. Maintenance Department personnel will complete weekly inspection and cleaning of all in-use oxygen concentrators and filters per manufacturers operating manual guidelines. Cleaning will be logged in the Weekly Concentrator Preventative Maintenance Log form. 3. Maintenance Department personnel will ensure all oxygen concentrators are checked weekly and monthly to ensure	6/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING: _____ B. WING _____	05/07/2021

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4 243	Continued From page 22 diagnosis of Chronic Respiratory Failure, Cardiac Arrest, Congestive Heart Failure, Tracheostomy, Atrial Fibrillation, Dysphagia, Gastrostomy, Hyperlipidemia, Hypertension, Dementia, Quadriplegia. R45 had a doctor's order to use oxygen with the ventilator. 2. During an observation, on 05/05/21 at 11:15 AM, of R63's room, a NewLife Elite Oxygen Concentrator was noted at bedside providing oxygen to R63. The air particle filter located on the back of that oxygen concentrator appeared dirty with lint and/or dirt on it. A review of the EHR showed that R63 was admitted on 04/02/21 with a diagnosis of Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Heart Failure, Respiratory Failure with Hypoxia, Respiratory Failure with Hypercapnia, Atherosclerotic Heart Disease, Hyperlipidemia, Encephalopathy, Meckel's Diverticulum, Colitis, Acute Kidney Failure, Vascular Disorder of Intestine, Emphysema, Colostomy, Gastrostomy, Tracheostomy, Dysphagia, Septic Shock, Paralytic Strabismus. R63 had a doctor's order to use oxygen as needed. On 05/06/21 at 11:20 AM, Staff Nurse (Nurse) 1 was queried about the air particle filter cleaning process. Nurse 1 stated that they did not clean that filter and that they did not have any current process in place to clean it. On 05/06/21 at 11:30 AM, Unit Supervisor (Supvr) 2 was queried about the air particle filter cleaning process. Supvr 1 stated that they did not clean that filter and did not have any current process in place to clean it. On 05/07/21 at 11:32 AM, a review of the Service	4 243	they are in good working order. Items noted needing preventative maintenance will taken out of use and exchanged for working units to ensure resident safety and infection control. 4. Maintenance Coordinator will monitor logs and report compliance with inspection and cleaning to the Quarterly Quality Committee.	

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4 243	Continued From page 23 manual for the NewLife Elite Oxygen Concentrator, Section 3.2.1 - Cleaning the air intake gross particle filter stated the following: the patient must clean this filter weekly ... The filter may require daily cleaning if the NewLife unit operates in a harsh environment ... Section 4.1.1 Air intake gross particle filter stated the following: the external air intake gross particle filter is located on the back of the unit. You can easily remove it by hand. Instruct the patient to clean this filter weekly.	4 243		